
Debate at the coalface

HIV, confidentiality and 'a delicate balance': a reply to Leone Ridsdale

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Author's abstract

The passing on of information to GPs by genito-urinary doctors is to be encouraged but is not always possible and ultimately the patient's wishes and confidentiality must be respected if sexually transmitted diseases and HIV infection are to be controlled.

Infected health-care workers should seek counselling and medical support and clear guidelines from professional organisations which are in existence. However, they will only do so if strict confidentiality is maintained and assurance about future employment can be given.

Leone Ridsdale has raised some practical and important points regarding the current practice of genito-urinary medicine (GUM)/sexually transmitted diseases (STDs) and care of patients with proven or potential HIV infection (1). She raised two main issues, the passing of information to the general practitioner (GP), and the right to know the serostatus of an individual if he/she constitutes a potential risk to others.

1. Passing of information to the general practitioner

I believe that a patient with an STD, but in particular with a chronic and life-threatening condition such as HIV infection, is usually best served if his GP is aware of the diagnosis. A patient with HIV infection is likely to develop medical and psychological problems that can only be dealt with adequately by the GP if he is aware of the underlying condition. Why does this not happen? We have to accept, even though I don't like to, that a patient with an STD can feel ashamed and find it difficult to consult. Often he finds it easier to overcome this by seeking help in the relatively anonymous atmosphere of a clinic, away from his district of residence and delivered by someone other than his family doctor who may have known him for many years and who also looks after his sexual partner or parents. I am not suggesting that GPs would behave in anything but a totally discreet and confidential

manner in such circumstances, but rather that patients don't understand and perceive this. The majority (85 per cent) of patients seen at a clinic such as the Middlesex are self-referred and usually don't live in Bloomsbury.

Even though I am concerned to deliver appropriate care to the consulting patient, I also have a public health function of tracing sexual contacts and creating a sympathetic service which will be used by as many people as needs be. The service must be uncensorious and non-moralistic. It is both bad medicine and bad manners to impose one's own value system and morals upon patients. It is also essential that patients trust the doctor and in particular feel that everything that is said is confidential, otherwise they will either not come or, once there, will not feel free to give full details.

Often, for the reasons given earlier, patients do not wish their GP to know of their attendance. This has been particularly highlighted in recent years with the advent of HIV infection. Sadly, there are other reasons, apart from fears that confidentiality will be broken, why patients with this infection will not consult their GP. For example, GPs have been perceived as lacking knowledge about HIV and sympathy towards gay men. This has resulted in STD clinics, especially in London, providing ongoing primary care. We don't want this and I always try to persuade patients to involve their GP and in most instances they see the sense of this. I believe that all GUM doctors should do likewise. It is rare nowadays for patients with HIV not to see the sense of involving their GP in their continuing care. However, the crunch comes in the rare instance when a patient adamantly refuses to involve the GP. How is the public health best served in such a situation? I believe that to force the issue, and break confidentiality without consent by telling a GP that his patient is infected, will create a climate of fear amongst my client group. I wish to do everything possible to control HIV and in my position this will come from attracting people for screening and check-ups. If they are fearful that information will be passed on without permission many will not come to my service. In summary, therefore, I would agree that GPs should be involved in the care of patients with HIV and that they have a more important role to play than the hospital specialist. I, and my colleagues in

Key words

AIDS; general practitioners; health care workers; confidentiality.

GUM, must do all we can to encourage patients to involve their GP but come the crunch I believe that more damage is done by flying in the face of patients' wishes and that everything must be done to avoid driving HIV and, of course, other STDs underground, the end result of which is that more, not fewer, are put at risk.

2. Right to know serostatus of an individual

Dr Ridsdale raises the issue of the potentially HIV-infected partner who is working in an operating theatre and might be accidentally injured during a surgical invasive procedure and thus constitute a possible risk to patients. The first thing to say is that there is little evidence that a patient has been infected by an HIV-positive surgeon or assistant. One report exists of transmission by an infected dentist to three of his patients (2). Two other studies have shown that patients operated upon by a UK surgeon with AIDS had not seroconverted and that only one of 616 patients operated upon by an American surgeon with AIDS was subsequently antibody positive (3,4). This patient was an injecting drug user. Despite the extremely low risk it would be wrong to be cavalier, and on the basis of our knowledge that health care workers have seroconverted following needlestick injuries, we should develop a strategy that assumes that an infected health care worker carrying out an operative procedure could infect a patient. The Department of Health and their Expert Advisory Group on AIDS examined this issue in 1988 and a further review is currently taking place (5). The position in 1988 was that 'the great majority of clinical procedures pose no risk of HIV transmission. The only area for concern for patient safety is in relation to invasive procedures where unavoidable injury to the operator can occur, despite meticulous attention to technique'. The General Medical and Dental Councils advise doctors and dentists who think they could be infected to seek counselling and testing and to discuss modification of work practices if found to be seropositive (6,7). Similar guidance has also been given by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (8).

All this is sensible and is the easy part of the exercise to ensure that patients are not put at risk. However, how do we ensure that the majority of potentially infected health-care workers are identified? I believe, once again, that this is best achieved by creating a climate that allows such individuals to be treated with total confidentiality and to be offered occupational advice which is both sensible and uniformly agreed upon nationally. Finally, individuals must feel confident prior to consultation that they will not lose their jobs within the health service, and that at worst they will have to modify their techniques or retrain in a different branch of their profession. It is only when such a sympathetic safety net is in place that people will consult and the public will be maximally protected. If individuals feel their disclosure will not be treated

confidentially and that they will lose their jobs as a result, they will not present for testing, will go 'underground' and the public will be at greater risk. No doubt some would argue that 'soft liberal humanism' is inappropriate and that all of us should be tested. As with universal compulsory testing of populations this is hard to put into operation and raises major issues of civil liberties and the penalties that would be employed if an individual refused to be tested.

I am uncertain from Dr Ridsdale's article whether she was concerned that the infected patient was not prepared to tell his partner who worked in theatre that he could have been infected through their sexual relationship or whether the partner, already knowing this, did not wish to be tested. Assuming the latter, Dr Ridsdale should offer counselling and try to make the partner realise that he could constitute a theoretical risk to others if positive and that it would be appropriate to be tested. The GMC have given guidance to the medical profession 'that any doctors who think there is a possibility that they may have been infected with HIV should seek appropriate diagnostic testing and counselling ...'. They also make it clear that failure to modify professional practice if necessary, when HIV-positive, and to remain under medical supervision would allow the attending doctor to report that person's unfitness to practise to 'an appropriate body' (6). Again, the UKCC's advice is similar but less clear in terms of invoking sanctions (8). In the case quoted by Dr Ridsdale the health-care worker is not known to be HIV-positive, only to be exposed. Thus, one could not force the worker to be tested nor report him, since his status is unknown. While this may sound alarming, in fact, as with the desire to involve GPs, few refuse to see the need to protect others, and agree to be tested. This is also so for a patient prior to surgery who usually sees the sense of allowing the surgeon to know his antibody status.

It is evident that the issues raised by Dr Ridsdale do not have clear black and white answers. Those who suppose that the answer is obvious and that all that is required is a permissive interpretation of confidentiality and universal testing have not thought through the issues and fail to realise that a draconian approach often drives that which one wishes to discover through one's fingers and underground.

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overseen by multidisciplinary boards. But whatever other intellectual liaisons it may seek and make, and however fruitful such liaisons may prove, health care ethics should surely not forget that it remains *essentially* a subclass of philosophy in so far as its central function is 'the critical evaluation of assumptions and arguments'.

References

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- (4) See reference (3): 8.